DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445382	A. BUILDING _____ B. WING _____	08/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIGEON FORGE CARE & REHAB CENTER	415 COLE DRIVE PIGEON FORGE, TN 37863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to notify the	F 157	Pigeon Forge Care and Rehab does not believe and does not admit that any deficiencies existed, before, during or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves All rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil, or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathy Bryan	Administrator	9-8-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 physician of failure to administer medications for one resident (#7) of twenty-two residents reviewed. The findings included: Resident #7 was admitted on September 2, 2009, with diagnosis including Chronic Pain, Opioid Chemical Dependency, Anxiety, Depression, Spinal Stenosis, Torticollis (stiff neck with muscle contractions), Hypertension, and Mononeuritis (inflammation of nerves). Medical record review of the Minimum Data Set (MDS) dated May 22, 2011, revealed the resident had no memory or cognitive impairments, was on a scheduled pain regimen, received PRN (as needed) pain medications, and experienced frequent moderate pain that limited day to day activities. Medical record review of a physician's order dated August 3, 2011, revealed, Morphine Sulfate (narcotic for pain) SR (sustained release) 60mg every eight hours. Medical record review of the nurse's notes dated August 5 and 6, 2011, revealed the resident complained of pain and was requesting pain medications on August 5, at 2:00 p.m., August 6, at 2:00 p.m., and 8:00 p.m., and August 7, 2011, at 9:30 a.m., 12:00 p.m., 12:30 p.m., and 1:00 p.m. Medical record review of the nurse's notes dated August 6, 2011, at 12:45 p.m., revealed, the resident had a fall, refused to be evaluated at the Emergency Room (ER) and "...MD notified new	F 157	**F 157-D** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #7 no longer resides in the facility **How do you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken?** Residents with routine orders for controlled medication for pain have the potential to be affected. Those with routine controlled substances for pain management were reviewed on 8/10/2011. None had documentation of medication having been with held since the survey. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** RN #2 received informal 1:1 education and counseling by the DON and SDC on August 9, 2011 and again on August 23, 2011 by the DON on the importance of physician/NP notification if pain medication has been with held, along with documentation of the notification and professional nursing rationale for with holding the medication. All licensed nurses will receive in service education by the SDC, DON, or designee regarding the importance of physician/NP	

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F 157	Continued From page 2 orders given..." Medical record review of the physician's order revealed an order to change Morphine to 30mg. every six hours, with no date or time on the order. Medical record review of the Medication Record dated August 2011, revealed the resident received Morphine 60 mg. on August 5, 2011, at 10:00 p.m., and did not receive the Morphine doses scheduled for August 6, 2011, at 6:00 a.m., 2:00 p.m., 9:00 p.m., or August 7, 2011, at 3:00 a.m., and 9:00 a.m. Telephone interview with the physician on August 8, 2011, at 2:30 p.m., confirmed the physician was notified of the resident's fall, but was unaware the resident did not receive the scheduled pain medications as ordered on August 6 and 7, 2011. Interview with LPN #2 on August 8, 2011, at 3:00 p.m., in the Staff Development Office, confirmed the resident did not receive the scheduled Morphine on August 6 or 7, 2011, due to nursing concerns regarding safety of administering pain medications after the fall and over sedation. Continued interview confirmed the physician was not notified the resident did not receive the scheduled pain medications..	F 157	**F 157-D cont.** notification in event controlled medication for pain is with held, to ensure the physician/ NP is aware. This education will be completed by September 12, 2011. **How the corrective actions will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** One time per week audits were done for the month of August, 2011 beginning 8/10/2011. Those residents who had routinely ordered controlled substance pain medication with held had documentation that the NP was notified. Beginning September 1, 2011, medication administration records will be audited daily (Monday-Friday) by the ADONs/ designee to assure physician/NP was notified in event pain medication was with held. This audit will be done for 4 weeks, then three times per week for 2 months and monthly there after. Any issues identified will be addressed immediately. The findings of these audits will be reviewed at the Performance Improvement Committee monthly for three months and quarterly thereafter. This committee will discuss and make any necessary revisions or recommendations. The Performance Improvement Committee consists of, at minimum, the administrator, medical director, director of nursing, social services director, and maintenance director. Date of compliance—September 16, 2011.	9-16-11
F 159 SS=D	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.	F 159		

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F 159	Continued From page 3 The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.	F 159	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The responsible party for resident #12 was notified on August 8, 2011by the Business Office Manager and permission obtained to use monies to make purchases for the resident. **How do you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken?** Residents with a resident trust fund account with the facility have the potential to be affected. A 100% audit of all resident trust fund accounts was conducted by the business office staff on August 8, 2011when the oversight was observed by the survey team. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** Business office staff was in-serviced on the policy and procedure concerning resident trust accounts by the administrator on August 9, 2011. The receptionist will review each account at the first of each month for any account within $200.00 of the allowed amount. A notice will be sent to the family and/or responsible party by receptionist for any account that is within this allowed $200.00 limit.	

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F 159	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on review of resident trust account, facility policy review, and interview, the facility failed to notify the responsible party when the balance of the resident trust account was within $200.00 of the SSI (Social Security Income) resource limit ($2000.00) for one (#12) of fifty-five resident trust fund accounts reviewed. The findings included: Review of resident #12's trust fund account revealed the following balances: on June 3, 2011=$2266.85; on July 1, 2011=$2316.93; and on August 3, 2011=$2361.05. Review of the facility's policy Resident Accounts revealed "...a resident on medical assistance must be notified whenever their funds are within $200 of their resource asset limit..." Interview on August 8, 2011, at 8:55 a.m., with the Business Office Manager and the Receptionist, in the office, confirmed the resident/resident's responsible party had not been notified the resident's trust fund account was within $200.00 of the SSI resource limit until last week (the first week of August 2011).	F 159	**F 159-D cont.** **How the corrective actions will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The administrator will do a 100% audit of trust fund accounts by the 20th of each month to assure accuracy of accounts and appropriate notifications have occurred. The regional Business Office Manager's consultant will review the audits during scheduled visits. The findings of these audits will be reviewed at the Performance Improvement Committee monthly for three months and then quarterly thereafter. This committee will discuss and make any necessary revisions or recommendations. The Performance Improvement Committee consists of, at minimum, the administrator, medical director, director of nursing, social services director, and maintenance director. Date of compliance—September 16, 2011	9-16-11
F 201 SS=D	483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the	F 201	**F 201-D** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Facility Interdisciplinary Team made decision to initiate an emergency discharge of resident #7 to ensure the safety and well-being of this resident and other residents. The facility made attempts to help the local hospital find appropriate placement and placement was obtained.	

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F 201	Continued From page 5 facility; The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; The safety of individuals in the facility is endangered; The health of individuals in the facility would otherwise be endangered; The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or The facility ceases to operate. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure a resident was not involuntarily discharged for one resident (#7) of twenty-two residents reviewed. The findings included: Resident #7 was admitted on September 2, 2009, with diagnosis including Chronic Pain, Opioid Chemical Dependency, Anxiety, Depression, Spinal Stenosis, Torticollis (stiff neck with muscle contractions), Hypertension, and Mononeuritis	F 201	**F 201 D cont.** **How do you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken?** Residents with aggressive behaviors or behaviors that make them a threat to themselves or others have the potential to be affected. In the event of this type of behavior occurring, social services will be notified for follow up, to include an initial evaluation by social services and follow up interventions as indicated by the evaluation. Residents with behavioral symptoms will be offered psychiatric services by 9/1/2011 along with any new admissions going forward. Residents who decline psychiatric services will be offered the services on a quarterly basis (by social services) to coincide with the MDS assessment. Residents who are identified with new onset of behaviors or changes of behavioral symptoms will be offered psychiatric services when new behaviors or changes are noted. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** The Interdisciplinary Team will be inserviced by the Administrator, Director of Nursing, and Social Services Director on the proper process for Emergency Discharge/ Transfer due to behaviors with potential to	

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F 201	Continued From page 6 (inflammation of nerves). Medical record review of the Nurse's Notes dated August 7, 2011, at 9:45 p.m., revealed "...IDT (Interdisciplinary Team) decision to not take the resident back d/t (due to)...threatening, aggressive behaviors toward others and (self) by not allowing nursing staff to provide...treatment and overall care and meds ..." Interview with the Social Services Director on August 8, 2011, at 8:00 a.m., in the Social Services Office, confirmed no documentation the resident had threatened self or other residents and the Director had not received any verbal reports from staff the resident was a danger to self or others. Further interview confirmed the resident had exhibited escalating behaviors the past two weeks and the facility had not attempted psychiatric intervention or counseling. Interview with the Administrator on August 9, 2011, in Administrator's office, at 1:50 p.m., confirmed the resident had been discharged; a decision had been made to not allow the resident to return to the facility; the resident had exhibited escalating behaviors with no attempts by the facility to obtain psychiatric/psychological consults; and there was no documentation of the resident being a threat to self or others.	F 201	**F 201 cont.** cause harm to the resident or others by September 12, 2011. Content to include appropriate interventions including psychiatric/psychological consultations and documentation of the resident being a threat to self and/or others prior to initiating the Emergency Discharges/Transfer Process. **How the corrective actions will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** A log will be kept by the social services director to track the offer of services, acceptance or declination of services, including date offered, date of initial visit by the provider, and if applicable, date discharged from psych caseload. The administrator will review the log weekly X4 weeks and monthly there after. This psychiatric services referral log will be reviewed at monthly Performance Improvement committee meeting to ensure compliance with the process. An audit of discharges will be completed monthly by the Social Services Director to ensure that all discharges have followed the proper discharge/transfer process. The findings will be reviewed by the Performance Improvement Committee monthly for three months and quarterly thereafter. The Performance Improvement committee consists of, at a minimum, the administrator, medical director, director of nursing, social work services director and maintenance director. Date of compliance—September 16, 2011	9-16-11
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide	F 225		

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F 225	Continued From page 7 registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to investigate an injury of unknown cause, for one (#8) of twenty-two residents reviewed.	F 225	F225-D **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #8 was assessed by the wound nurses for bruises on August 11, 2011. **How do you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected. 100% of residents have been assessed by the LPN wound nurses between August 11, 2011 and August 18, 2011. Any observed changes including bruises are investigated for cause and documented on the investigation report. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** The LPN staff nurse who failed to investigate for the cause of the bruising received1:1 education and counseling by the Director of Nursing on August 23, 2011,concerning the importance of a full investigation and determination of cause of any injury, including bruises.	

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F 225	Continued From page 8 The findings included: Resident #8 was admitted to the facility on June 26, 2002 with diagnoses including Alzheimer's disease, Diabetes Mellitus II, Senile Delusions, Hypertension, and BiPolar Disorder. Medical record review of the Minimum Data Set (MDS) dated May 29, 2011, revealed the resident had difficulty with long and short term memory, and severe difficulty with decision making skills. Continued review of the MDS revealed the resident required assistance with all activities of daily living, was non ambulatory, and incontinent of bowel and bladder. Review of facility documentation revealed on December 2, 2010, the resident sustained bruises on the left inner thigh, the lower left leg, and the left lower abdominal area. Continued review of the facility documentation revealed no documentation for the time of day discovered, the description of the bruises, the sizes of the bruises, and no investigation was provided to determine the cause of the bruises. Interview with the Interim Director of Nursing on August 8, 2011, at 8:00 a.m., in the Chapel, confirmed the bruises of unknown origin had not been investigated to determine the cause of the bruises.	F 225	F 225 cont. Licensed nurses will receive in-service education regarding thorough investigation of injuries, including bruises by the Staff Development Coordinator or designee by September 12, 2011. Staff LPNs and RNs are responsible to fully investigate the cause of bruises. Incident investigations are reviewed the next business day by the clinical team to ensure causes of any injury, including bruises, has been determined. The clinical team, which meets Monday-Friday (excepting holidays), is composed of the director of nursing, assistant directors of nursing, MDS coordinators, Rehabilitative Services manager, Social Work Services director, and Restorative Nurse manager. Investigations of bruising will be reviewed at an additional weekly audit for 4 weeks to ensure root cause has been identified, then every two weeks and monthly thereafter. **How the corrective actions will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** Results of investigations involving bruising will be reviewed at the monthly Performance Improvement meeting. This review will include any issues regarding failure to thoroughly investigate cause of bruises monthly for three months and then quarterly thereafter. The Performance Improvement Committee consists of, at a minimum, the administrator,	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial	F 250		

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F 250	Continued From page 9 well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide medically-related social services for one resident with behaviors (#7) of twenty-two residents reviewed. The findings included: Resident #7 was admitted on September 2, 2009, with diagnosis including Chronic Pain, Opioid Chemical Dependency, Anxiety, Depression, Spinal Stenosis, Torticollis (stiff neck with muscle contractions), Hypertension, and Mononeuritis (inflammation of nerves). Medical record review of the Minimum Data Set dated May 22, 2011, revealed the resident had no memory or cognitive impairments, no behavior exhibited, and had diagnoses of Anxiety Disorder and Depression and received antipsychotic, antianxiety, and antidepressant medications. Medical record review of the Physician's Orders dated May through August 2011, revealed no order for Psychiatric Services. Medical record review of the Comprehensive Care Plan dated May 23, 2011, revealed a problem of "...Resident displays persistant anger with self and others, repetitive health/anxious concerns, and verbally abusive with staff...psychological/psychiatric consult..."	F 250	medical director, director of nursing, social services director and maintenance director. Date of compliance—September 16, 2011 **F 250-D** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #7 no longer is a resident in the facility. **How do you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken?** Residents with aggressive behaviors or behaviors that make them a threat to themselves or others have the potential to be affected. In the event of this type of behavior occurring, social services will be notified by the assistant director of nursing or the charge nurse assigned to the resident, for follow up, to include an initial evaluation by social services and follow up interventions as indicated by the evaluation. Residents with behavioral symptoms will be offered psychiatric services by 9/1/2011 along with any new admissions going forward. Residents who decline psychiatric services will be offered the services by social services on a quarterly basis to coincide with the MDS assessment. Residents who are identified as having new onset or changes of behavioral symptoms will be offered psychiatric services at that time as well.	9-16-11

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	445382	A. BUILDING _____ B. WING _____	08/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIGEON FORGE CARE & REHAB CENTER	415 COLE DRIVE PIGEON FORGE, TN 37863

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F 250	Continued From page 10 Medical record review of the Social Service Progress Notes dated August 27, 2010 through August 7, 2011, revealed, staff reported the resident had "...behavioral symptoms..." on June 28, 2011, July 15, and 25, 2011, and August 7, 2011. Observation on August 7, 2011, at 12:52 p.m., revealed the resident in a wheel chair propelling self. Continued observation revealed the resident opened the door at the Nurses Station, yelling loudly at Licensed Practical Nurse (LPN) #2, "I have dressed myself...(used restroom)... can I have my medicine now?" Continued observation revealed several staff members came to the Nurses Station and attempted to redirect the resident. Continued observation revealed the resident continued to have an increase in anger,had verbally abusive behaviors toward staff, requesting pain medications, and was sent to the emergency room for escalating behaviors at 1:30 p.m. Interview with the Social Services Director August 9, 2011, at 8:00 a.m., in the Social Services Office revealed the staff had reported the resident's "...abusive and threatening behaviors (toward staff) increased in the past two weeks..." and confirmed the Social Services Director had not referred the resident for psychological/psychiatric consultation.	F 250	**F250-D cont.** **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** The social worker will be responsible to obtain the signed consent for psychiatric services and request a signed order be obtained from the physician or NP. The social worker is responsible to notify the psychiatric services provider of the need for services. A log book will be kept by the social worker to track the offer of services, acceptance or declination of services, including date offered, date of initial visit by the provider, and if applicable, date discharged from psych caseload. The administrator will review the log weekly X4 weeks and monthly there after. **How the corrective actions will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** This log will be reviewed and discussed at monthly Performance Improvement Committee to make any necessary revisions or recommendations to ensure compliance with the process for three months and then quarterly thereafter.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309	The Performance Improvement Committee consists of the administrator, medical director, director of nursing, social services director and maintenance director. Date of compliance—September 16, 2011	9-16-11

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F 309	Continued From page 11 mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to manage pain for one resident (#7) of twenty-two residents reviewed. The findings included: Resident #7 was admitted on September 2, 2009, with diagnosis including Chronic Pain, Opioid Chemical Dependency, Anxiety, Depression, Spinal Stenosis, Torticollis (stiff neck with muscle contractions), Hypertension, and Mononeuritis (inflammation of nerves). Medical record review of the Minimum Data Set (MDS) dated May 22, 2011, revealed the resident had no memory or cognitive impairments, was on a scheduled pain regimen, received PRN (as needed) pain medications, and experienced frequent moderate pain that limited day to day activities. Medical record review of a physician's order dated July 15, 2011, Oxycodone (narcotic for pain) 15mg. (milligrams) every six hours PRN. Medical record review of a physician's order dated August 3, 2011, revealed, Morphine Sulfate (narcotic for pain) SR (sustained release) 60mg every eight hours.	F 309	**F 309-D** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #7 no longer resides in the facility **How do you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken?** Residents with routine orders for controlled medication for pain have the potential to be affected. Those with controlled substances ordered routinely for pain management were reviewed on 8/10/2011. None had documentation of medication having been with held since the survey. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** RN #2 received informal 1:1 education and counseling by the DON and SDC on August 9, 2011 and again on August 23, 2011 by the DON on the importance of physician/NP notification if pain medication has been with held, along with documentation of the notification and professional nursing rationale for with holding the medication.	

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F 309	Continued From page 12 Medical record review of the Nurse's Notes dated August 5 and 6, 2011, revealed the resident complained of pain and was requesting pain medications on August 5, at 2:00 p.m., August 6, at 2:00 p.m., and 8:00 p.m., and August 7, 2011, at 9:30 a.m., 12:00 p.m., 12:30 p.m., and 1:00 p.m. Medical record review of the nurse's notes dated August 6, 2011, at 12:45 p.m., revealed, the resident had a fall, refused to be evaluated at the Emergency Room (ER) and "...MD notified new orders given ..." Medical record review of a physician's telephone order revealed an order to change Morphine to 30mg. every six hours, with no date or time on the order. Medical record review of the Medication Record dated August 2011, revealed, the resident received Morphine 60 mg. on August 5, 2011, at 10:00, p.m. and did not receive the Morphine doses scheduled for August 6, 2011, at 6:00 a.m., 2:00 p.m., 9:00 p.m., or August 7, 2011, at 3:00 a.m., and 9:00 a.m. Medical record review of the Medication Record dated August 2011, revealed the resident received one dose of the Oxycodone 15mg. PRN medication on August 6, 2011 at 8:00 p.m. Observation on August 7, 2011, at 12:52 p.m., at the nurse's station revealed the resident in a wheel chair propelling self. Continued observation revealed the resident opened the door at the Nurse's Station, yelling loudly at Licensed Practical Nurse (LPN) #2, "I have dressed myself...(used restroom)...can I have my medicine now?" Continued observation revealed several staff members came to the Nurse's	F 309	**F 309-D cont.** All licensed nurses will receive in service education by the SDC, DON, or designee regarding the importance of physician/NP notification in event pain medication is with held, to ensure the physician/NP is aware. This education will be completed by September 12, 2011. **How the corrective actions will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** Weekly reviews were done in August, 2011 after survey exit. Any with held controlled pain medication was documented on the MAR and noted to have NP notification. Beginning September 1, 2011, medication administration records will be audited daily (Monday-Friday) by the ADONs/ designee to assure physician/NP was notified in event pain medication was with held. This audit will be done for 4 weeks, then three times per week for 2 months. Any issues identified will be addressed immediately. The findings of these audits will be reviewed at the Performance Improvement Committee monthly for three months and then quarterly thereafter. This committee will discuss and make any necessary revisions or recommendations. The Performance Improvement committee consists of, at minimum, the administrator, medical director, director of nursing, social services director, and maintenance director. Date of compliance—September 16, 2011	9-16-11

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F 309	Continued From page 13 Station and attempted to redirect the resident. Continued observation revealed the resident continued to have an increase in anger and verbally abusive toward staff, requesting pain medications, and was sent to the (ER) for escalating behaviors at 1:30 p.m. Telephone interview with the physician on August 8, 2011, at 2:30 p.m., confirmed the physician was notified of the resident's fall, but was unaware the resident did not receive the scheduled pain medications as ordered on August 6 and 7, 2011. Interview with LPN #2 on August 8, 2011, at 3:00 p.m., in the Staff Development Office, confirmed the resident did not receive the scheduled Morphine on August 6 or 7, 2011, due to nursing concerns regarding safety of administering pain medications after the fall and over sedation. Continued interview confirmed the physician was not notified the resident did not receive the scheduled pain medications and was not consulted for additional orders for pain control. Continued interview confirmed the resident had been on scheduled narcotic pain medications for many years, was experiencing increased agitation, and demanding behaviors which might have been related to withdrawal of pain medications. Interviews with the physician on August 8, 2011 at 2:30 p.m., by telephone, LPN #2 at 3:00 p.m., in the Staff Deveolpment Office, and with Nurse Practioner #1 on August 9, 2011 at 10:35 a.m., in the Staff Development Office confirmed the resident's pain was not managed.	F 309		
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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F 323 SS=D	Continued From page 14 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to maintain an environment free of hazards and failed to ensure a safety device was functional for one resident (#10) of twenty-two residents reviewed. The findings included: Resident #10 was admitted to the facility July 30, 2003, with diagnoses including Atherosclerotic Cardiovascular Disease, Diabetes, Depression, and Chronic Obstructive Airway Disease. Medical record review of the Minimum Data Set (MDS) dated June 23, 2011, revealed the resident had severe cognitive impairment and required staff supervision and physical assistance with transfers and ambulation. Medical record review of the resident's care plan dated June 27, 2011, revealed "...at risk for fall related injury R/T (related to) hx (history) of falls...staff to assist with ambulation and/or locomotion as needed...door alarm to bathroom door..." Further medical record review of the	F 323	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The bed wheels for resident #10, were locked immediately on 6/4/11; the bathroom door alarm was replaced immediately on July 1, 2011. **How do you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken?** Residents' beds with unlocked wheels/ malfunctioning wheel locks have the potential to be affected. Housekeeping Supervisor completed a 100% audit on August 9, 2011 of all bed locks to determine if locked or if they worked appropriately. Identified issues were immediately corrected. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** Housekeeping staff was in-serviced by the housekeeping supervisor on August 17, 2011, to check bed wheels to ensure bed wheels are locked as part of their daily routine of assigned rooms. Facility staff were in-serviced by Staff Development Coordinator on August 30 and August 31, 2011 on the importance of checking that bed wheels are locked as part of daily routine.	

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F 323	Continued From page 15 resident's care plan revealed "...res (resident) requires assistance with ADLs (activities of daily living) R/T decreased safety awareness..." Medical record review of a "Fall/Change of Function Status" form dated June 4, 2011, at 5:30 a.m., revealed "...res observed sitting on floor beside bed - states backed up to sit down and the bed rolled away..." Medical record review of a "Fall/Change of Function Status" form dated July 1, 2011, at 12:50 p.m., revealed "...resident observed lying in floor in bathroom. Laceration to the bridge of the resident's nose...Neurochecks started...resident transferred to...(named) Medical Center for evaluation and treatment..." Observation on August 7, 2011 at 12:50 p.m. revealed the resident, alert, resting in bed, bed alarm in place, and receiving oxygen via nasal cannula. Interview with the Assistant Director of Nursing (ADON) #1, on August 9, 2011, at 11:30 a.m., in the medical records office, confirmed the bed wheels were not locked on June 3, 2011 and caused the resident to fall. Further interview with ADON #1 on August 9, 2011, at 11:30 a.m., in the medical records office, confirmed the bathroom door alarm was broken and not sounding on July 1, 2011, and the resident was found down in the bathroom on routine rounds.	F 323	**F 323-D cont..** Housekeeping staff started daily audits of bed wheel locks on 8/23/2011. Any unlocked wheels were immediately locked. The housekeeping supervisor began 100% audit two times per week on 8/25/2011. This was increased to three times per week on 9/1/2011. Any wheels observed to be unlocked were immediately locked. Follow up to the ADON or charge nurse for follow up with nursing staff. Nursing staff began receiving in service education by the Staff Development Coordinator on August 30, 2011on the importance of functioning bathroom door alarms. This will be completed by September 12, 2011. Door alarm checks are part of licensed nurse responsibility throughout their shift. Extra alarms and batteries are readily available at the nurses station in the event an alarm malfunctions. The ADONs or designee will monitor door alarm functioning daily for two weeks, then three times a week for two weeks, and weekly thereafter for two months. Results will be documented on an audit tool. **How the corrective actions will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** Results of these audits will be reviewed by the Performance Improvement Committee monthly for three months and quarterly thereafter. The committee will discuss and make any necessary revisions or	
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY	F 372		

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F 372	Continued From page 16 The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to maintain the area around the facility dumpster in a clean and sanitary manner. The findings including: Observation of the dumpster area on August 7, 2011, at 10:00 a.m., with the Assistant Dietary Manager, revealed the following items stored behind two of the outside buildings with the dumpster between the buildings: Multiple abandoned shower and geri chairs; stacks of old used wood pieces; abandoned oxygen concentrator; open plastic pails filled with water; a white plastic tubular two shelf cart, with a tray at the bottom, filled with greenish colored water; an old, rusty, abandoned, deteriorated Jeep with jagged edges and no top; and other miscellaneous pieces of debris. Observation and interview with the Administrator on August 9, 2011, at 9:15 a.m., at the dumpster area, confirmed the above items and debris around the dumpster area.	F 372	F 323—cont. recommendations. The Performance Improvement committee consists of, at a minimum, the administrator, medical director, director of nursing, social services director and maintenance director. Date of compliance—September 16, 2011 **F 372** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** On August 9, 2011 the abandoned stacks of shower and Geri chairs, stacks of old used wood pieces, abandoned oxygen concentrator, open plastic pails filled with water, white plastic tubular two shelf cart with tray at bottom, and other miscellaneous pieces of debris were removed. The old rusty jeep has been removed as of Sept 6, 2011. **How do you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken?** Facility resident have the potential to be affected by this deficient practice. Environmental Rounds were completed on August 9, 2011 by the Maintenance Supervisor.	9-16-11
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State	F 425	**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** Maintenance staff were in-serviced by the	

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F 425	Continued From page 17 law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide pharmaceutical services in a timely manner for one resident (#7) of twenty-two residents reviewed. The findings included: Resident #7 was admitted on September 2, 2009, with diagnosis including Chronic Pain, Opioid Chemical Dependency, Anxiety, Depression, Spinal Stenosis, Torticollis (stiff neck with muscle contractions), Hypertension, and Mononeuritis (inflammation of nerves). Medical Record review of a telephone order dated August 3, 2011, at 6:00 p.m., revealed, Ativan 0.5 mg. BID (twice daily) and Ativan 1 mg. HS (nightly).	F 425	**F 372-D cont.** administrator on August 9, 2011 on the proper maintenance of the area around the facility dumpster to maintain a clean and sanitary environment. The administrator or Maintenance Director will complete a weekly inspection to ensure that maintenance staff maintain the area in a clean and sanitary manner for four weeks and then monthly thereafter **How the corrective actions will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** Maintenance will do a monthly environmental rounds audit of the dumpster area for three months reporting findings to the monthly Performance Improvement Committee. If there are no additional findings of non-compliance then the audit will be completed quarterly thereafter. The Performance Improvement committee consists of, at a minimum, the administrator, medical director, director of nursing, social services director and maintenance director. Date of compliance—September 16, 2011 **F 425-D** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #7 no longer resides at the facility. **How do you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken?**	9-16-11

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F 425	Continued From page 18 Medical record review of the Medication Record dated August 2011, revealed the resident did not receive Ativan 0.5mg. on August 3, 2011, at 8:00 p.m., and August 4, 2011, at 8:00 a.m., and 4:00 p.m. Medical record reviewed a telephone order dated August 4, 2011, "...OK to hold Ativan until available..." Review of the Shipping Manifest from the facility's pharmacy revealed the medication left the pharmacy on August 4, 2011 at 4:59 p.m., and arrived at the facility on August 4, 2011, time not documented. Medical record review of the nurse's notes dated August 6, 2011, at 12:45 p.m., revealed, "...MD notified new orders give..." Medical record review of the physician's order revealed an order to change Morphine to 30mg. every six hours, with no date or time on the order. Medical record review of the Medication Record dated August 2011, revealed, the resident did not receive Morphine 30mg. on August 6, 2011 at 9:00 p.m. Medical record review of the Nurses's Notes dated August 6, 2011 at 8:00 p.m., revealed, the resident was told "...Morphine was being sent STAT from pharmacy..." Medical record review of the Shipping Manifest from the facility's Pharmacy revealed the medication left the pharmacy on August 6, 2011 at 9:12 p.m. and arrived at the facility on August 6, 2011, time not documented. Interview with LPN #2 August 8, 2011, at 2:34	F 425	**F 425-D** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #7 no longer resides at the facility. **How do you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken?** Residents with STAT orders for controlled substances from the provider pharmacy have the potential to be affected. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** RN#2 has received informal 1:1 in service education and counseling on August 9, 2011 and again August 23, 2011 by the DON regarding the process for ordering STAT controlled substances from the pharmacy, including the processing time frame which per the pharmacy provider is at least 4 hours; correct interpretation of time line information on the shipping manifest; and the importance of documenting the time of receipt from pharmacy on the packing slip. This in service education included appropriate communication with the pharmacy and the physician/NP to ensure timely delivery of controlled substances. Licensed nurses will receive this same in service education by September 12, 2011 by the Staff Development Coordinator or designee.	

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F 425	Continued From page 19 p.m., in the Staff Development Office confirmed "...an order to decrease Morphine was received prior to resident being sent to ER on August 6, 2011 at 3:30 p.m..." Interviews with the Administrator, Staff Development Coordinator, Corporate Nurse Consultant, and LPN#2 on August 8,2011, at 2:34 p.m., in the Staff Development Office, and with Corporate Nurse Consultant on August 9, 2011, at 1:45 p.m., in the Chapel, confirmed STAT was to be delivered in two hours to facility, and the facility failed to acquire medications in a timely manner.	F 425	F 425—cont. In the event the resident has need of pain management before the STAT medication is anticipated to arrive, the nurse will again contact the physician or NP and review medications available in the emergency drug kit that may be administered to provide a measure of relief until the STAT medication arrives from the pharmacy. STAT orders for controlled substances and any substitutes will be reviewed by the clinical team during daily clinical meeting (Monday-Friday) for compliance. The clinical team consists of the director of nursing, assistant directors of nursing, MDS coordinators, Rehabilitative Services manager, social work services director, and restorative nurse manager.	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441	**How the corrective actions will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** ADONs will audit all STAT orders for controlled substances Monday-Friday for 4 weeks, beginning September 1, 2011; two times a week for 4 weeks; and weekly thereafter. The audits will be reviewed by the Performance Improvement Committee monthly for three months and then quarterly thereafter. The Performance Improvement Committee consists of, at a minimum, the administrator, medical director, director of nursing, social services director and maintenance director. Date of compliance— September 16, 2011	9-16-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445382	A. BUILDING _____ B. WING _____	08/09/2011

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F 441	Continued From page 20 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to follow the infection control policy for one staff member (Dietary Manager) who presented with a contagious infection. The findings included: Observation on August 7, 2011, at 9:20 a.m., revealed the Dietary Manager entered the dietary department wearing a mask (over the mouth and nose), having difficulty with speaking and clearing the throat. Interview with the Dietary Manager at the same time confirmed the Dietary Manager had been sick and had gone to the emergency room in the morning of August 7, 2011. Continued observation on August 7, 2011, at 10:05 a.m., in the conference room revealed the Dietary Manager moved a food tray from the	F 441	**F 441-F cont.** **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** The ill employee was sent home by the supervisor immediately on August 7, 2011. **How do you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken?** Residents who came into contact with or were served food by this dietary employee had the potential to be affected. No residents developed symptoms of "strep throat" as result of this contact or food service by the employee. This employee was educated on August 10, 2011 by the Director of Nursing regarding the symptoms of "strep throat" measures to prevent spread to others; and recommendations for physician consult and treatment as outlined in CDC educational information from the CDC website. The education also reviewed dietary infection control protocol, including prompt reporting to the supervisor if symptomatic; concomitant review by the infection control nurse or other nurse designee and the importance of use of protective barriers such as face masks to prevent possible infection. In addition the human resources policy was reviewed which further supports the dietary specific policy.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	Continued From page 21 conference room to the chapel without the mask on the face. Continued observation on August 7, 2011, at 4:35 p.m., revealed the Dietary Manager walking down the hall toward and into the Dietary Department, without the mask on the face. Observation on August 7, 2011 at 10:20 a.m., 10:30 a.m., 1:30 p.m., 1:37 p.m., 2:10 p.m., 2:40 p.m., and 2:45 p.m., revealed the Dietary Manager, wearing the mask, at different areas of the nursing home including the main dining room, the dining room on the 200 hall, the chapel, and at the nurses' station on the 200 hall. Interview with the Dietary Manager on August 7, 2011, at 2:45 p.m., in the Chapel, confirmed the visit to the emergency room resulted in a diagnosis of "Strep Throat" and received an antibiotic, prednisone, and Chloraceptic spray. Review of the facility policy for Communicable & Contagious Diseases revealed, "...It is the policy of the company that Stakeholders with communicable or infectious disease(s) shall be restricted from providing direct nursing care or services to residents...Stakeholders who may have or develop symptoms (i.e., flu, pink eye shingles, strep throat, fever and others...or signs of a communicable or infectious disease(s),...must report such information to the Supervisor immediately..." Interview with the administrator on August 7, 2011, at 4:50 p.m., in the main lobby, confirmed the administrator was informed of the trip to the emergency room in the morning of August 7, 2011, by the Dietary Manager, and confirmed the Dietary Manager was wearing a mask.	F 441	**F 441-F cont.** **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** **Dietary staff will be in-serviced by the SDC on infection control practices for disease prevention as pertains to dietary staff , and include the importance of not working if symptomatic of an infection, including respiratory symptoms, by September 12, 2011.** Facility staff also received this infection control education by the Staff Development Coordinator by September 12, 2011. The infection control nurse (or ADONs in the absence of the infection control nurse) will maintain a list of staff sent home with symptoms of infection, including respiratory symptoms. Human Resources will maintain a file of return to work releases presented by staff. **How the corrective actions will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The list will be presented to the Performance Improvement Committee monthly for three months and quarterly thereafter. The committee will review and make recommendations or revisions as needed. The Performance Improvement Committee will consist of, at a minimum, the administrator, medical director, director of nursing, social services director and maintenance director. Date of compliance—September 16, 2011	9-16-11

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F 441	Continued From page 22 Interview with the infection control nurse on August 7, 2011, at 4:50 p.m., in the main lobby, confirmed the facility failed to follow the infection control policy.	F 441		